Healthcare Reform: A Lexicon for Educators

A guide to terminology in the fields of quality improvement, patient engagement, and inter-professional education – and the associated organizations, legislation, and resources.

**Author:** MAZI RASULNIA, PHD,
M CONSULTING LLC, BIRMINGHAM, AL

**Co-authors:** RELISA MITCHELL & LAURIE MURRAY, PHD, RN, MEDSCAPE LLC,
NEW YORK, NY
Recognizing the dramatic and far-reaching changes to healthcare sparked by the Affordable Care Act, Medscape Education is committed to providing education designed to help clinicians succeed in the face of a new healthcare paradigm. Likewise, Medscape Education has taken a lead role in helping supporters of professional medical education identify opportunities in alignment with the six priorities of the National Quality Strategy. The new healthcare environment brings with it a host of new terminology, stakeholder and legislative issues. Medscape offers you this handy lexicon to help you know “who’s who” and “what’s what” in the quality improvement landscape.
Regarding care, the ACA:
- Covers preventive care at no cost to plan subscribers. Patients may be eligible for recommended preventive health services with no copayment.
- Protects the choice of doctors. Patients can choose the primary care doctor they want from their plan’s network.
- Removes insurance company barriers to emergency services. Patients can seek emergency care at a hospital outside of their health plan’s network.

The ACA contains what is known as the “individual mandate,” which requires most individuals to obtain health insurance or potentially pay a penalty for noncompliance.

Regarding healthcare coverage, the ACA:
- Ends preexisting condition exclusions for children. Health plans can no longer limit or deny benefits to children younger than 19 years due to a pre-existing condition.
- Keeps young adults covered. If you are younger than 26 years, you may be eligible to be covered under your parent’s health plan.
- Ends arbitrary withdrawals of insurance coverage. Insurers can no longer cancel your coverage just because you made an honest mistake.
- Guarantees your right to appeal. You now have the right to ask that your plan reconsider its denial of payment.

Regarding costs, the ACA:
- Ends lifetime limits on coverage. Lifetime limits on most benefits are banned for all new health insurance plans.
- Reviews premium increases. Insurance companies must now publicly justify any unreasonable rate hikes.
- Helps plan subscribers get the most from their premium dollars. Premium dollars must be spent primarily on healthcare, and not on administrative costs.

The Patient Protection and Affordable Care Act (commonly referred to as ACA) was signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, the ACA represents the most significant regulatory overhaul of the US healthcare system since the passage of Medicare and Medicaid in 1965. US Department of Health & Human Services (HHS) agency consumer information website highlights several provisions of the ACA (HHS, 2015), described below.

The purpose of ACA is to promote innovation in healthcare delivery by accelerating the development, implementation, diffusion, and uptake of demand-driven and evidence-based products, tools, strategies, and findings. ACTION develops and disseminates scientific evidence about what does and does not work to improve healthcare delivery systems. It provides an impressive cadre of delivery-affiliated researchers and sites with a means of testing the application and uptake of research knowledge. This group was the successor to the Integrated Delivery System Research Network (IDSRN), a 5-year implementation initiative completed in 2005. (AHRQ, 2009a)

The Accelerating Change and Transformation in Organizations and Networks (ACTION) initiative is a model of field-based research designed to provide coordinated, high-quality care for their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending healthcare dollars more wisely, it will share in the savings it achieves for the Medicare program. (CMS, 2013a)

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A program to facilitate shared decision making, which calls for HHS to contract with an entity to develop independent standards for educational tools known as “patient decision aids” for preference-sensitive care. (IDMF, 2015a)

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Formerly known as the Agency for Health Care Policy and Research (AHCPR), AHRQ is one of several agencies within HHS. The mission of AHRQ is to “produce evidence to make healthcare safer, higher quality, more accessible, equitable, and affordable, and to work within the...”
U. S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used” (AHRQ, n. d., Mission & Budget)

AHRQ’s priority areas of focus include the following:

Improve healthcare quality by accelerating implementation of patient-centered outcomes research (PCOR). AHRQ invests in developing PCOR methods and training, and in disseminating PCOR findings. AHRQ will also invest in an initiative to disseminate and support the implementation of PCOR findings in primary care practices.

Make healthcare safer. AHRQ researches the ways patients experience preventable harm during their healthcare, why this harm occurs, and how to prevent it. AHRQ translates the results into practical tools for providers to:
- Make healthcare safer in hospitals and ambulatory and long-term care settings;
- Reduce harm associated with obstetrical care to mothers and babies;
- Improve safety and reduce medical liability by developing a guide for implementing a Communication and Resolution Program; and
- Accelerate patient safety improvements in nursing homes. (AHRQ, n.d., p. 1)

Increase accessibility by evaluating the ACA coverage expansions. The AHRQ will lead HHS efforts to evaluate the effects of the ACA-mandated Medicaid and Marketplace coverage expansions. The results will enable HHS and Congress to make better-informed decisions about the implementation of the ACA in terms of access, reduction in disparities, use and expenditures, outcomes, financial security, and employer offers and coverage take-up.

Improve healthcare affordability, efficiency, and cost transparency by improving the data, measures, and public reporting strategies for conveying information on healthcare price, cost, and quality, and by developing and spreading evidence and tools to measure and enhance the efficiency of health systems—the capacity to produce better quality health and outcomes while avoiding overutilization, or to maintain quality of health and outcomes with lower resource use. The AHRQ will analyze variations in quality and resource use and identify the factors that differentiate higher-performing from lower-performing systems.

References


ABMS
American Board of Medical Specialties

A nonprofit organization of 24 medical specialty boards (known as the “Member Boards”). The ABMS is the largest physician-vocational specialty certification organization in the United States. The ABMS Member Boards maintain a rigorous process for the evaluation and certification of physicians in more than 150 medical specialties and subspecialties. More than 80% of practicing physicians in the United States have achieved board certification by 1 or more of the Member Boards. (ABMS, 2015)

The ABMS Maintenance of Certification® (MOC) program supports lifelong learning by physicians. The ABMS also collaborates with other professional medical organizations and agencies to set standards for graduate medical school education and accreditation of residency programs. The ABMS makes information available to the public about the board certification of physicians and their participation in the ABMS MOC® program. (ABMS, 2015)

Reference

AIHC
The American Inter-professional Health Collaborative

An organization that promotes the scholarship and leadership necessary to develop inter-professional education and transform health education across the learning continuum for students, practitioners, and educators. (AIHC, 2012)

References


BTE
Bridges to Excellence

An initiative created by a group of employers, physicians, health plans, and patients that has come together to create programs that will help realign medical incentives around six key attributes identified by the Institute of Medicine (IOM, 2011) report. The IOM advocated bridging the chasm by redesigning the healthcare system around 6 key attributes to make the system safer, timelier, and more effective, efficient, equitable, and patient-centered (STEEEP). (IOM, 2001; NCQA, 2013)

Bridges to Excellence (BTE) has a number of programs that recognize and reward clinicians who deliver superior patient care. These programs measure the quality of care delivered in provider practices and place special emphasis on managing patients with chronic conditions, who are most at risk of incurring potentially avoidable complications. The BTE Recognition cover all major chronic conditions plus office systems and also include a real patient-centered medical home (PCMH) measurement scheme to promote comprehensive care delivery and strong relationships between patients and their care teams. (IOM, 2013; NCQA, 2013)

Physicians, nurse practitioners, and physician assistants who meet performance benchmarks for BTE Recognition can earn a range of incentives, sometimes including substantial cash payouts. Insurers and employers use these payouts from the savings they achieve through lower healthcare costs and increased employee productivity. (IOM, 2013)

BPCl
Bundled Payments for Care Improvement

An initiative that links payments for multiple services beneficiaries received during an episode of care that leads to more coordinated care at a lower cost to Medicare. (CMS, 2015)

Reference
Care coordination

A function that helps ensure that a patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.

References

CMS Innovation Center
Centers for Medicare & Medicaid Services

Established by section 1115A of the Social Security Act (as added by section 2021 of the Affordable Care Act), this is a warehouse of various tested or promising payment and service delivery models. The CMS Innovation Center is currently focused on testing new payment and service delivery models, evaluating results, advancing best practices, and engaging a broad range of stakeholders to develop additional models for testing. (CMS, 2015).

References

Change management

The application of evidence-based strategies, methodologies, and tools for preparing an organization to adapt to changing needs and achieving desired patient health outcomes.

Reference

CDS
Clinical Decision Support

A collection of tools used to enhance decision making in the clinical workflow. These tools include computerized alerts and reminders to care providers and patients, clinical guidelines, condition-specific order sets, focused patient data reports and summaries, documentation templates, diagnostic support, and contextually relevant reference information. (AHRQ, 2009b)

References

CQM
Clinical Quality Measures

Tools that help measure and track the quality of healthcare services provided by eligible professionals, eligible hospitals, and critical access hospitals within the healthcare system.

Reference
Coaching
A method of directing or instructing a person to achieve a goal or develop a specific skill or competency. (Meakim et al., 2013)

Reference

CQI
Continuous Quality Improvement
Routine patient feedback to practice, measuring patient outcomes against benchmarks or evidence-based practices and many other process and outcome measures.

Reference

Counseling, coaching, question prompts, motivational interviewing, decision aids, and helplines
Interventions that can be used to engage patients at various points of the care continuum. The ultimate goal of all the interventions is for patients to take action and be an active participant in their healthcare decisions. (Truesdell, 2012)

Reference

Data infrastructure
Technology, processes, tools, and standards needed to promote data sharing and consumption. (HITRC, 2013)

Reference

Data integration
A combination of technical and business processes used to combine data from disparate sources into meaningful and valuable information. (HITRC, 2013)

Reference

Debriefing
An activity that follows a simulation experience led by a facilitator to provide feedback regarding the participants’ performance. (Meakim et al., 2013)

Reference

CoC
Continuum of Care
An integrated system of care that guides and tracks patient care over time through a comprehensive array of health services spanning all levels of intensity of care. Including all aspects of care provided at home, by primary providers, specialists, social and mental health workers, and others involved in delivering care for a patient as part of a comprehensive treatment plan. (Truesdell, 2012)

Reference

Cueing
Providing clues, triggers, prompts, hints, and instructional support to participants during simulation-based training or learning. (Paige & Morin, 2013)

Reference

Decision aids
Tools designed for patients to become involved in decision making by making explicit the decision that needs to be made, providing information about the options and outcomes, and clarifying personal values. They are designed to complement, rather than replace, counseling from a health practitioner.

Reference

Disease prevention and health promotion
Services to address the health of patients before the onset of illness or occurrence of disease that also encourage patients to lead healthy lives by changing behaviors.

Disease self-management
Providing education and tools needed to help patients cope with chronic diseases such as managing stress, encouraging physical activity and good nutrition, communicating effectively with healthcare providers;
An electronic version of a patient’s medical history that is maintained by care providers over time and is a real-time longitudinal health record generated by one or more encounters in any care delivery setting. Normally includes all of the key administrative clinical data relevant to that person’s care under a particular provider, including demographics, progress notes, problems, medications, vital signs, medical history, immunizations, laboratory data, and radiology reports.

The EHR automates access to information and can streamline the clinician’s workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various information technology (IT) interfaces, including evidence-based decision support, quality management, and outcomes reporting. (CMS, 2012)

The use of EHRs is intended to strengthen the relationship between patients and clinicians. The data, and the timeliness and availability of it, will enable providers to make better decisions and provide better care.

The EHR can improve patient care by (CMS, 2012):

- Reducing the incidence of medical error by improving the accuracy and clarity of medical records;
- Making the health information available, thereby reducing duplication of tests and delays in treatment, and encouraging patients to be well informed to make better decisions; and
- Reducing medical error by improving the accuracy and clarity of medical records.

An EHR is different from an electronic medical record (EMR). An EMR contains the standard medical and clinical data gathered in only one provider’s office. EHRs go beyond the data collected in the individual provider’s office and include a more comprehensive patient history. EHRs can contain and share information from all providers involved in a patient’s care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than one healthcare organization.

Unlike EMRs, EHRs also allow patients’ health records to move with them to other healthcare providers, specialists, hospitals, nursing homes, and across states. (HealthIT.gov, 2013)

**References**


**EHR**

**Electronic Health Record**

**Engagement**

Engagement is the act of becoming involved that individuals must take in order to obtain the greatest benefit from available healthcare services. (Center for Advancing Health, 2010)

**Reference**

factor that uses a state-determined inflation adjustment rate. The methodologies for service rates are described in the individual Medicaid state plan. (CMS, 2013b)

Reference

Feedback
Information given or dialogue between participants, facilitator, simulator, or peer with the intention of improving the understanding of aspects of their performance. (Meakin et al., 2013)

Reference

Fidelity
Degree to which a simulation replicates reality. (Paige & Moin, 2013)

Reference

Gap analysis or needs assessment
The process of using quantitative and qualitative methods to systematically collect and analyze data to understand health or organizational needs. (CDC, 2010)

Reference

Health apps
Application programs that offer health-related services for smartphones and tablets.

Reference

HEDIS
Healthcare Effectiveness Data and Information Set

A set of standardized performance measures designed to ensure that consumers have the information they need to reliably compare the performance of healthcare plans. Healthcare Effectiveness Data and Information Set (HEDIS) is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA) (NCQA, 2014).

The performance measures in HEDIS are related to several significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. These performance measures (NCQA, 2014) include a standardized survey of consumers’ experiences, which evaluates the performance of healthcare plans in areas such as customer service, access to care, and claims processing.

Health plans seek NCQA (2014) accreditation by administering the HEDIS performance measures across their plans. In general, compliance with conventional reporting practices and HEDIS specifications for the following domains is measured:

- Effectiveness of care
- Access/availability of care
- Satisfaction with the experience of care
- Health plan stability
- Use of services
- Cost of care
- Informed healthcare choices
- Health plan descriptive information (NCQA, 2014)

HIE
Health Information Exchange

The capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged.

HIT
Health Information Technology

The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision making.

Reference


HITECH
Health Information Technology for Economic and Clinical Health

The HITECH Act seeks to improve American healthcare delivery and patient care through an unprecedented investment in health IT (HIT). The
HIMSS Healthcare Information and Management Systems Society

This global not-for-profit organization’s central focus is on better health through IT. The organization’s goal is to lead efforts to optimize health engagements and care outcomes using IT through leadership, education, events, market research, and media services around the world (HIMSS, 2015).

Reference

HIMSS Center for HCPFC Healthcare Information and Management Systems Society Center for Patient- and Family-Centered Care

A Healthcare Information and Management Systems Society (HIMSS) Foundation and the National eHealth Collaborative project, the center educates and engages providers and patients to co-connect by understanding the value of the adoption and use of health IT. (HIMSS Foundation, 2015a)

Reference


A model created to guide healthcare organizations in developing and strengthening their patient engagement strategies through the use of eHealth tools and resources. Designed to assist healthcare organizations of all sizes and in all stages of implementation of their patient engagement strategies (HIMSS Foundation, 2015b).

Reference

IMDF Informed Medical Decisions Foundation

Now a division of Healthwise, an organization working to advance evidence-based shared decision making. The goal is to help people make better health decisions.

Reference

IPA Independent Practice Association

A type of health maintenance organization (HMO) or other legal entity in which individual practitioners or smaller groups of physicians see patients enrolled in the HMO but also treat their own patients who are not HMO participants. Compensation to the physician is based on either a per patient fee or a discounted fee schedule (HRA, 2015).

Reference

Human patient simulators

A full-sized patient mannequin that blinks, breathes, and has a heartbeat and pulse. Provides a virtual simulation of almost every major bodily function. Can be used for a range of scenarios from physical examination to major trauma.

Resource

Integrated Delivery Network

Groups of physicians, hospitals, HMOs, and other facilities and providers that work together to offer care to a specific geographic region or market. The make-up of the networks varies to address
Integrated care delivery

Brings together inputs, delivery, management, and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction, and efficiency. (Coulter, 2012)

ICD-9
International Classification of Diseases, Ninth Revision

A classification system designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems. (CMS, 2013c)

The ICD-9 provides a format for reporting causes of death on the death certificate. The reported conditions are then translated into medical codes through use of the classification structure and the selection and modification rules contained in the applicable revision of the ICD, published by the World Health Organization. These coding rules improve the usefulness of mortality statistics by giving preference to certain categories, by consolidating conditions, and by systematically selecting a single cause of death from a reported sequence of conditions. (CDC, 2010)

The ICD has been revised periodically. The ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as of 1994. The ICD-10 is currently being phased in to replace the ICD-9 in various segments of the US healthcare system. (ECM, 2013c) On October 1, 2014, ICD-10 code sets replaced ICD-9 code sets. The transition to ICD-10 is required for everyone covered by HIPAA. The change to ICD-10 does not affect current procedural terminology coding for outpatient procedures and physician services. The 11th revision of the ICD classification has already started and will continue until 2015. (WHO, 2013)

Interoperability

The ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.

Inter-professional collaborative practice

When multiple healthcare workers from different professional backgrounds work together with patients/ families and communities to deliver the highest quality of care. (WHO, 2010)

Inter-professional Education

When students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes. (WHO, 2010)

Inter-professional teamwork

The levels of cooperation, coordination, and collaboration characterizing the relationships between
The Joint Commission

A nonprofit organization that accredits more than 20,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality and reflects an organization’s commitment to meeting certain performance standards.

The mission of the Joint Commission is “to continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.” (The Joint Commission, 2013)

Reference


MOC Maintenance of Certification

The process of physicians keeping their certification up to date through one of the 24 medical specialty boards of the ABMS (see ABMS, page 6), as well as some of the medical specialty boards of the American Osteopathic Association. In 2000, the Member Boards of ABMS agreed to evolve their recertification programs to one of continuous professional development: the ABMS Maintenance of Certification (MOC®). The ABMS MOC ensures that a physician is committed to lifelong learning and competency in a specialty and/or subspecialty by requiring ongoing measurement of six core competencies adopted by the ABMS and the Accreditation Council for Graduate Medical Education in 1999. (ABMS, 2014)

The six core competencies are measured in a variety of ways, some of which vary according to specialty, using a 4-part process that is designed to keep certification continuous. The ABMS MOC program plans were approved in 2006, and the boards are now in the process of implementation. (ABMS, 2014)

The Centers for Medicare & Medicaid Services (CMS) promotes MOC through its Physician Quality Reporting System (PQRS). The PQRS is a voluntary reporting program that provides incentive payments to identified EPs who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. (See FFS)

Physicians who are incentive-eligible for 2014 PQRS can receive an additional 0.5% incentive payment when MOC Program Incentive requirements have been met. Physicians cannot receive more than one additional 0.5% MOC Program Incentive, even if they complete an MOC Program in more than one specialty. (CMS, 2014)

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MAP Measure Applications Partnership

A public–private partnership convened by the National Quality Forum (NQF) to provide input to the HHS on the selection of quality and efficiency measures for use in public reporting and performance-based payment programs. The MAP initiative is the first of its kind, blending the views of diverse groups in order to provide recommendations to the federal government in advance of the regulatory rule-making process. The MAP collaboration represents a variety of interests, including consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers, in an effort to promote fair and balanced input to HHS on performance measure selection. (NQF, 2013b)

Reference


Resource


MU Meaningful Use

MU is the set of standards, defined by the Incentive Programs of the CMS that governs the use of EHRs. The goal of meaningful use is to improve US healthcare by promoting the spread of EHR. (HealthIT.gov 2014)

Using certified EHR technology to:
1) Improve quality, safety, efficiency, and reduce health disparities, 2) Engage patients and family, 3) Improve care coordination (and population and public health), and 4) Maintain privacy and security of patient health information. The overall mission of meaningful use is: better clinical outcomes, improved population health outcomes, increased transparency and efficiency, empowered individuals, and more robust research data on health systems. (HITRC, 2013)

The benefits of the meaningful use of EHRs include:

- **Complete and accurate information.** EHRs give providers the information they need to deliver the best possible care. They will know more about their patients and their health history before they enter the examination room.

- **Better access to information.** EHRs facilitate greater access to the information that providers need to diagnose health problems earlier and improve the outcomes of their patients. EHRs also allow information to be shared more easily among doctors’ offices, hospitals, and across health systems, leading to better coordination of care.

- **Patient empowerment.** EHRs will help empower patients to take a more active role in their health and in the health of their families. Patients can receive electronic copies of their medical records and share their health information securely over the Internet with their families. (HealthIT.gov, 2014)

The HITECH Act establishes incentive payments under the Medicare and Medicaid programs that can be earned by EPs, EHs, and critical access hospitals that demonstrate that they meaningfully use certified EHR technology (CMS, 2013a)

Reference

Centers for Medicare & Medicaid Services (CMS). (2013a)

References


The NCQA’s quality improvement efforts are primarily focused on improving the quality of health and healthcare. Sets clear goals to help the public focus its efforts on improving the quality of health and healthcare. Developed the NCQA’s Health Plan Report Card, which rates plans in five categories: Access and Service, Quality Measures, Staying Healthy, Getting Better, and Living with Illness. (NCQA, 2015d)

NPP. National Priorities Partnership

A partnership of 52 national organizations with a shared goal of achieving “better health, and a safe, equitable, and value-driven healthcare system.” (NQF, 2015b, para 1). The NPP was convened by the NQF (see NQF below) as part of its overall mission to improve the healthcare system.

The NPP member organizations collaborated to create the National Quality Strategy (NQS), which sets clear goals to help the public focus its efforts on improving the quality of health and healthcare.

MLN Medicare Learning Network

A free Medicare education and information resource. (CMS, 2015a)


Medicare Star Rating


Multidisciplinary team approach

An approach that encompasses all members of the treatment and/or care team, allowing coordination of all relevant aspects of a patient’s healthcare needs. These team members consider every facet involved with the patient’s care, treatment planning, and disease or symptom management, resulting in more effective communication among the full healthcare team and the patient. (PHYTEL, 2012; Truesdell, 2012)

References


Narrow-network plan

A limited provider network health plan to control cost. (McKinsey & Company, 2014)

References


NLC National Learning Consortium

Represents a centralized hub for training tools and resources designed to aid healthcare professionals in identifying and disseminating best practices during the implementation, adoption, and support of EHR systems. (HealthIT, 2014b)

References


PE/A Medicaid


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performance measures, also called quality measures, NQF reviews, endorses, and recommends the use of
created to develop and implement a national strategy
National Quality Forum
NQF
nqs/nqs2012annlrpt.pdf
Resource
Department of Health and Human Services (HHS). (2012). Annual
progress report to congress. National Strategy for Quality Improvement
Reference
http://www.qualityforum.org/
NQF performance measures are intended to:
■ Make our healthcare system more information-rich;
■ Point to actions physicians, other clinicians, and
organizations can take to make healthcare safe and equitable;
■ Enhance transparency in healthcare;
■ Ensure accountability of healthcare providers; and
■ Generate data that helps consumers make informed
choices about their care. (NQF, 2015)
The NQF operates under a 3-part mission to improve the
quality of healthcare by:
■ Building consensus on national priorities and goals for
performance improvement, and working in partnership
to achieve them;
■ Endorsing national consensus standards for
measuring and publicly reporting on performance; and
■ Promoting the attainment of national goals through
education and outreach programs. (NQF, 2015)
NQF measures
National Quality Forum measures
Standards that are evaluated through the Consensus
Development Process for measuring and publicly
reporting on the performance of different aspects of
the healthcare system. Standards endorsed by NQF
are widely viewed as the “gold standard” for
the measurement of healthcare quality. (NQF, 2015)
Reference
NQMC
National Quality Measures Clearinghouse
A public resource consisting of a database and website
that provide information on specific evidence-based
healthcare quality measures and measure sets.
Sponsored by Agency for Healthcare Research and
Quality (AHRQ) to promote widespread access to quality
measures by the healthcare community and other
interested individuals.
■ Making our healthcare system more information-rich;
■ Enhancing transparency in healthcare;
■ Ensuring accountability of healthcare providers; and
■ Generating data that helps consumers make informed
choices about their care. (NQF, 2015)
The NQF operates under a 3-part mission to improve the
quality of healthcare by:
■ Building consensus on national priorities and goals for
performance improvement, and working in partnership
to achieve them;
■ Endorsing national consensus standards for
measuring and publicly reporting on performance; and
■ Promoting the attainment of national goals through
education and outreach programs. (NQF, 2015)
Reference
NQS
National Quality Strategy
This term is shorthand for the National Strategy for
Quality Improvement in Health Care, a nationwide
effort to align public and private interests to improve the
quality of health and healthcare. Part of the ACA, the NQS is
guided by 3 aims: to provide better care, to facilitate
healthy people/healthy communities, and to provide
affordable care.
To achieve these aims, the NQS applies 6 priorities
that address the range of quality concerns that affect
most Americans. These aims and priorities have the
potential to rapidly improve health outcomes and
increase the effectiveness of care for all populations.
(AHRQ, 2011)
The 6 NQS priorities are:
■ Making care safer by reducing harm caused in the
delivery of care;
■ Ensuring that each person and family are engaged
as partners in their care;
■ Promoting effective communication and
coordination of care;
■ Promoting the most effective prevention and
treatment practices for the leading causes of
mortality, starting with cardiovascular disease;
■ Working with communities to promote wide use of
best practices to enable healthy living, and
■ Making quality care more affordable for
individuals, families, employers, and governments
by developing and spreading new healthcare
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by developing and spreading new healthcare
delivery models. (AHRQ, 2014)
Reference

All 52 NPP member organizations worked together to
advocate for the creation of the NQS and continue to
shape its direction by offering annual input to the US
Secretary of HHS. (NQF, 2015a)
Together, the NPP member groups:
■ Identify national goals that correspond to the priorities
put forth in the NQS;
■ Provide input on measures for tracking national
progress toward the goals; and
■ Offer guidance on strategic opportunities to accelerate
improvement. (NQF, 2013b)

References
qualityforum.org/Publications/2012/11/Critical_Paths_for_Creating_Data_Platforms__Care_Coordination.aspx

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Medscape
EDUCATION
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Patient activation

An individual’s knowledge, skills, and confidence for managing his/her own health and healthcare. (Health Affairs, 2014; Hibbard, Green, & Overton, 2013)

References

Hibbard, J. H., Green, J. J., & Overton, V. (2013). Patients with lower activation associated with higher costs; Delivery systems should know their patients’ scores. Health Affairs, 32(2), 192-203.

Patient advocacy

An individual or organization acting as a liaison between the patient and provider to ensure the needs (medical, social, psychological, community support and other) of patients are addressed as part of an integrated and comprehensive patient-centered care approach. (Gilkey & Earp, 2009)

Reference

Patient Centered Care

Active involvement of patients and their families and respecting individual and cultural values, needs, and choices/decisions in care delivery and decision-making. (PHYTEL, 2012, Tuesdell, 2012)

References


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References


PCORI

Patient-Centered Outcomes Research Institute

A US-based nongovernmental institute created as part of a modification to the Social Security Act by clauses in the Patient Protection and Affordable Care Act (ACA) Authorized by Congress to conduct research to provide information about the best available evidence to help patients and their healthcare providers make more informed decisions. The aim of PCORI’s research is to give patients a better understanding of the prevention, treatment, and care options available, and the science that supports those options. (PCORI, 2013a)

The institute is responsible for setting priorities for national clinical comparative effectiveness research; its ultimate purpose is to improve healthcare delivery and outcomes by producing and promoting high-integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader healthcare community. (PCORI, 2013b)

References


Patient-Centered Medical Home

Patient Centered Medical Home (PCMH) is not a place: it is a promising model for transforming the organization and delivery of primary care. The PCMH offers a way to organize primary care that emphasizes care coordination and communication in order to transform primary care in fundamental ways that can lead to higher quality and lower costs and can improve patients’ and providers’ experience of care.

The PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient’s lifetime to maximize health outcomes. (ACP, 2015)

The PCMH has become a widely accepted model for how primary care should be organized and delivered throughout the healthcare system and is intended to ensure that patients are treated with respect, dignity, and compassion and to enable strong and trusting relationships with providers and staff.

The Patient-Centered Primary Care Collaborative (PCPCC) describes PCMH as:

■ Patient-centered: A partnership among practitioners, patients, and their families that ensures that decisions respect patients’ wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.

■ Comprehensive: Delivered by a team of care providers who are wholly accountable for a patient’s physical and mental healthcare needs, including prevention and wellness, acute care, and chronic care.

■ Coordinated: Care is organized across all elements of the broader healthcare system, including specialty care, hospitals, home healthcare, community services, and supports. (ACP, 2015b)

The AHRQ website has an online resource website that provides policymakers and researchers with evidence-based resources about the PCMH approach and its potential to transform primary care and improve the quality, safety, efficiency, and effectiveness of US healthcare. (AHRQ, n.d.)

References

Patient education

A planned, systematic, sequential, and logical process of teaching and learning provided to patients and clients in all clinical settings. (Jones and Bartlett, n.d.)

Reference


Patient empowerment

Allowing patients to access to choices that affect health outcomes. (Center for Advancing Health, 2010; Nursing Alliance for Quality Care, 2011)

Reference


Patient engagement

The use of a set of principles and strategies for empowering patients to actively participate in actions related to their own health. The concept of engagement takes into account the need for continuous and regular interaction between patients and providers throughout healthcare delivery. (Barello, Graffigna & Vegni, 2012; Canadian Foundation for Healthcare Improvement, 2015; Coulter, 2012; Gamble, 2014; Health Affairs, 2014; Health Research and Education Trust, 2013)

Reference


The use of a set of principles and strategies for empowering patients to actively participate in actions related to their own health. The concept of engagement takes into account the need for continuous and regular interaction between patients and providers throughout healthcare delivery. (Barello, Graffigna & Vegni, 2012)

Reference


Patient/family outreach

Proactive efforts to understand and reach out to the patient and family to ensure adherence to treatment, with the goal of sustaining new healthy behaviors or for prevention screening outreach.

Reference


Patient health literacy

The degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services available to be able to make appropriate health decisions. (The Joint Commission, 2007)

Reference

Patient-oriented research

A continuum of research, conducted by multidisciplinary teams in partnership with relevant stakeholders, that engages patients as partners, focuses on patient-identified priorities, and improves patient outcomes. (Canadian Institutes of Health Research, 2014)

Reference

Patient portal

A secure online website that gives patients convenient 24-hour access to personal health information to either communicate with healthcare providers and/or gain access to portions of their medical record and other services. (HealthIT.gov, 2013)

Reference

Patient technology competence

The skills, competence, and use of technology that a patient may have to access his or her own health information or electronic personal health record. (Rogers & Mead, 2004)

Reference

P4P Pay for Performance

An emerging movement in health insurance, in which providers are compensated by payers for meeting certain preestablished measures for quality and efficiency. P4P programs have been implemented by both Medicare and private insurers. The CMS has numerous demonstration projects underway to pilot P4P programs in a range of care settings, from primary care clinics to hospitals. The goal is to improve the transparency and accountability of the quality improvement process as a complement to other incentives. (CMS, 2005)

There are financial incentives attached to P4P to drive clinical care objectives. Using quantitative metrics, a percentage of physician compensation can be tied to achieving specific clinical benchmarks in the care they provide. The key difficulty in establishing a P4P program is in choosing appropriate benchmarks. In general, stressing adherence to evidence-based guidelines for care (e.g., ordering of pneumonia vaccines for all patients over the age of 65 years) should be preferred over patient outcomes (e.g., number of diabetic patients with an HbA1c less than 70%), because patient outcomes often depend on factors outside the provider’s control (CMS, 2005; Health Affairs, 2012, Integrated Healthcare Association, 2014)

References


PMPM Per Member Per Month

A type of capitation payment model for healthcare, in which a provider organization is given a set amount of money each month to provide an agreed upon range of services for the patients enrolled in the program for the period of time covered by the agreement. Depending on the contract, the types of services provided to patients enrolled in the program may vary. The PMPM payments are meant to incentivize providers to implement wellness strategies that keep their patients healthier and reduce the need for expensive acute care services. (Alguire, 2015)

Managed care organizations use capitation payments to control healthcare costs, through controlling the use of healthcare resources by putting the physician at financial risk for services provided to patients. In order to ensure that patients do not receive suboptimal care through underutilization of healthcare services, managed care organizations measure (and report on) rates of resource utilization in physician practices. These reports are made available to the public as a measure of healthcare quality and can be linked to financial rewards, such as bonuses. (Alguire, 2015)

Capitation is a fixed amount of money per patient per unit of time (per year in the case of PMPM), paid in advance to the physician for the delivery of healthcare services. The amount of money paid is determined by the services provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and so can vary from one region to another. When the primary care provider signs a capitation agreement, a list of specific services that must be provided to patients is included in the contract. (Alguire, 2015)

References


Performance improvement

Positive changes in capacity, process, and outcomes within an organization. (CDC, 2011; HealthIT.gov, 2013a)

References


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Performance management

The practice of actively using performance data to improve patient health. This involves the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an organization achieves desired results. (CDC, 2011; HITRC, 2013)

References

Performance recording

The use of video cameras and microphones for educators to use during a learning activity and offer feedback to participants. Learners also have the opportunity to watch recordings of their learning activities to observe their performance and identify opportunities for improvement. (Patow, 2005)

Reference

PHRs

Personal Health Records

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards that can be drawn from multiple sources while being managed, shared, and controlled by the individual. (HITRC, 2013; HealthIT.gov, 2013b)

References

PQA

Pharmacy Quality Alliance

A 501(c)3 designated nonprofit alliance with more than 100 member organizations. The mission is to improve the quality of medication management and use across healthcare settings, in order to improve patients’ health. The PQA undertakes this effort through a collaborative process to develop and implement performance measures and to recognize examples of exceptional pharmacy quality. (PQA, 2015)

As a multistakeholder, consensus-based membership organization, PQA collaboratively promotes appropriate medication use and develops strategies for measuring and reporting performance information related to medications. (PQA, 2015)

References

PQRS

Physician Quality Reporting System

A reporting program run by the Centers for Medicare & Medicaid Services (CMS) that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by EPs. The PQRS provides an incentive payment to practices with EPs identified on claims by their individual National Provider Identifier and Tax Identification Number. EPs qualify for the payments by satisfactorily reporting data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B FFS beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the PQRS also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services. The PQRS reporting set pulls data from the PCPI®, HEDIS, and other measures, but is primarily vetted by the NQF. (CMS, 2015)

Reference

PCPI®

Physician Consortium for Performance Improvement

A national, physician-led program convened by the American Medical Association (AMA) and dedicated to enhancing healthcare quality and patient safety. The organization seeks to accomplish aligning patient-centered care, performance measurement, and quality improvement. The PCPI develops, tests, implements, and disseminates evidence-based measures that reflect the best practices and best interest of medicine. (AMA, 2015)

The PCPI focuses on improving patient health and safety by:
- Promoting the implementation of effective and relevant clinical performance improvement activities;
- Identifying and developing evidence-based clinical performance measures and measurement resources that enhance the quality of patient care and foster accountability;
- Promoting the implementation of effective and relevant clinical performance improvement activities; and
- Advancing the science of clinical performance measurement and improvement. (AMA, 2015)

The PCPI® is nationally recognized for measure development, specification and testing of measures, and enabling the use of measures in EHRs. The PCPI’s measure development resources include a measurement protocol, a position statement on the evidence base required for measure development, a composite framework, specification and categorization of measure exceptions, and an outcomes measure framework. (AMA, 2015a)

Reference

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The use of technology and statistical and analytic methods to search through massive amounts of information and predict patient outcomes and behaviors. (Winters-Miner, 2014)


Population health

A term used to describe the “potent opportunity for health care delivery systems, public health agencies, community-based organizations, and many other entities to work together to improve health outcomes in the communities they serve” (Stoto, 2013). One of the three elements in the Institute for Healthcare Improvement’s (IHI) Triple Aim for improving the US healthcare system.


PCIP

Primary Care Bonus Incentive Payment Program

This program allows physicians in primary care practices a 10% bonus regardless of which Zip code they practice in. The 10% will be paid quarterly and will be based on the actual amount paid, not the allowed amount. If the EPs practices in a Health Professional Shortage Areas (HPSA) area, they will qualify for both the PCIP and HPSA bonus payments. (ACP, 2015a)


Reference


Resource


Public health

Refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. The focus is on the conditions in which people, an entire population, not on individual patients or diseases. Thus, public health is concerned with the total system, not only the eradication of a particular disease. According to World Health Organization (2015a), the 3 main public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- To ensure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.


QCDR

Qualified Clinical Disease Registry

A new reporting mechanism available for the Physician Quality Reporting System (PQRS) for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. (CMS, 2015g)


Quality Improvement

Systematic and continuous actions that lead to measurable improvement in healthcare services and the health status of targeted patient groups. Also, the process of continuous effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes that achieve equity and improve the health of individuals or communities. (American Telemedicine Association, 2012; HITRC, 2013; Riley et al. 2010)


QHP

Qualified Health Plans

An insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing, and meets other requirements. (Healthcare.gov, n.d.)


QI

Quality Improvement

Quality improvement is systematic and continuous actions that lead to measurable improvement in healthcare services and the health status of targeted patient groups. Also, the process of continuous effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes that achieve equity and improve the health of individuals or communities. (American Telemedicine Association, 2012; HITRC, 2013; Riley et al. 2010)


QIos

Quality Improvement Organizations

A CMS-coordinated group of health quality experts and clinicians that assist Medicare providers with quality improvement and review of quality concerns. There is one QIO for each US state territory, and the District of Columbia. (QIO’s, 2015)


Quality and safety

Quality care is safe, effective, patient-centered, timely, efficient, and equitable. Safety is the foundation upon which all other aspects of quality care are built. (Hibbard & Green, 2003)

Quality measures

Tools that help quantify healthcare processes, outcomes, patient perceptions, and organizational structures and/or systems. A method for quantifying patient healthcare in comparison to a baseline criteria (such as using evidence-based recommendations as baseline for cholesterol measurement). (CMS, 2019a)

References


RMDs

Remote Monitoring Devices

Using mobile medical device(s) to perform a routine test and send the test data, such as blood pressure or weight, to a healthcare professional in real-time. These data are sent directly to a healthcare professional for test and send the test data, such as blood pressure or weight, to a healthcare professional in real-time. These data are sent directly to a healthcare professional for instant feedback.

References


Hilliard, J. H., & Green, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences: Fewer data on costs. Health Affairs, 2, 207-214

SDM

Shared Decision Making

A process in which healthcare providers and patients collaboratively discuss and select tests, interventions, management, and next steps that are based both on evidence-based research and patient preferences. (Barello, Graffigna, & Vegni, 2012; Gambie, 2014; Hilliard, Green, & Overtont, 2013; PHYTEL, 2012; Truesdell, 2012)

An approach to clinical decision making in which both the provider and the patient are recognized as having unique expertise relevant to care decisions. (AHRQ, n.d.; Gambie, 2014)

References


Hilliard, J. H., & Green, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences: Fewer data on costs. Health Affairs, 2, 207-214


Simulation

An interactive teaching method that allows the learner to practice techniques and apply knowledge in scenarios that would be experienced in the real world, in a controlled and safe environment. (Abdolsinaa & Roy, n.d.)

References

Standardized patient

A layperson or actor hired and trained to portray the role of actual patient, presenting a faculty-defined clinical scenario with patient history and physical symptoms for teaching and assessment purposes. (Anderson, n.d.)

References

Telemedicine

The use of medical information exchanged from one site to another via electronic communications to improve a patient’s health status. (American Telemedicine Association, 2012)

References


HHS

US Department of Health & Human Services

The US Department of Health and Human Services, or HHS (2014), is the US government’s principal agency for protecting the health of Americans and delivering essential human services. The HHS has 11 separate divisions, including 8 public health
QIEs safety; substance abuse treatment and prevention; and research; preventing disease; ensuring food and drug and Medicaid programs; health and social science responsibilities include administration of the Medicare
The HHS administers more than 300 programs covering a broad spectrum of activities. Some of the agency’s chief responsibilities include administration of the Medicare and Medicaid programs; health and social science research; preventing disease; ensuring food and drug safety; substance abuse treatment and prevention; and improving maternal and infant health. (HHS, 2014)

URAC
Utilization Review Accreditation Commission
An independent nonprofit organization that promotes healthcare quality and efficiency through its accreditation, education, and measurement programs. This organization is independent of any single stakeholder group. The governing board of directors was founded with representatives from all affected constituencies: consumers, providers, employers, regulators, and industry experts. The URAC offers a wide range of quality benchmarking programs and services through which organizations can validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards-development process, URAC ensures that all stakeholders are represented in its efforts to establish meaningful quality measures for the entire healthcare industry. (URAC, 2013)

VBP
Value-Based Payment
An approach to paying for healthcare that financially rewards physicians who provide healthcare that is high value—that is, high in quality while also low in cost. The Centers for Medicare & Medicaid Services (CMS) will be implementing a VBP for Medicare and Medicaid providers by 2015, as mandated by the Affordable Care Act (ACA). To accomplish this, CMS will begin applying a value modifier under the Medicare Physician Fee Schedule that will factor cost and quality data into the calculations for payments for physicians. (CMS, 2015i)

The reward formula is a simple system: performance is assessed in two dimensions (quality and cost), and payments go to physicians who have above-average performance in 2 dimensions. Physicians who perform worse than average or choose not to be involved are paid less, and there will be no change for physicians with average performance. The maximum bonus is about 2% of Medicare fees, and the maximum penalty is approximately 1%. Scoring physicians relative to one another achieves budget neutrality for CMS. For physicians, it eliminates the effects of physicians about the amount of improvement that will be necessary to receive a bonus or avoid a penalty. (Chien & Rosenthal, 2013; CMS, 2015i)

The CMS will implement VBP in 2 stages. Groups of 100 or more physicians who submit claims to Medicare under a single tax identification number will be subject to the value modifier in 2015. All physicians who participate in FFS Medicare will be affected by the value modifier by January 1, 2017. (CMS, 2015i)

The ACA directs the CMS to provide information to physicians and medical practice groups about their resource use and the quality of care provided to their Medicare patients, including patterns of resource use cost among different healthcare providers, as part of Medicare’s efforts to improve the quality and efficiency of clinical care. (ACP, n.d.) This actionable information is intended to help physicians improve the care they furnish, as the CMS moves toward physician reimbursement that rewards value rather than volume. (CMS, 2015i)

The program’s 2 primary components for accomplishing this are Quality and Resource Use Reports (also known as Physician Feedback Reports) and development and implementation of the value-based payment modifier. (CMS, 2015i)


Virtual procedure stations
A computer-controlled simulation device is available for teaching such as bronchoscopy, colonoscopy, blood-drawing, puncture technique, and after care. At the end of the session, the software assigns the learner a score based on technique and generates a report that helps track the student’s progress over time and identify areas for improvement. (Patow, 2015)

Wireless and wearable health technology
Mobile devices that monitor health conditions in real time and automatically import that data into health information systems, and allowing for quicker detection and faster response to medical emergencies. (Patow, 2015)